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A LONG-STANDING WHO COLLABORATIVE PROJECT ON EARLY IDENTIFICATION AND BRIEF ALCOHOL INTERVENTION IN PRIMARY HEALTH CARE COMES TO AN END

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Editorial for Addiction

After 25 years, the *WHO Collaborative Project on Detection and Management of Alcohol-related Problems in Primary Health Care* has finally come to an end. A report on the fourth and final phase of the project, entitled *Development of Countrywide Strategies for Implementing Early Identification and Brief Intervention in Primary Health Care,* was recently posted on the WHO web site [1]. Research centres from Australia and 11 European countries (Belgium [Flanders], Bulgaria, Denmark, Finland, France, Italy, Russian Federation (North-west Russia], Slovenia, Spain [Catalonia], Switzerland and United Kingdom [England]) took part in the Phase IV study and each contributed a chapter to the report. The study was coordinated by the Centre for Alcohol and Drug Studies, Newcastle upon Tyne, UK and an international website http://www.who-alcohol-phaseiv.net was managed by the Health Department of the Government of Catalonia in Barcelona.

Previous phases of the Collaborative Project were:

Phase I (1982-87): a reliable and valid screening instrument for detecting hazardous and harmful drinkers in primary health care (PHC) settings was developed (the AUDIT questionnaire) [2];

Phase II (1987-92): a cross-national clinical trial of screening and brief intervention in PHC was carried out [3];

Phase III (1993-99): the practices and perceptions of general medical practitioners (GPs) regarding alcohol screening and brief intervention were assessed (Strand 1) [4], in-depth telephone interviews with GPs and personal interviews with key informants were conducted (Strand 2) [5] and methods for encouraging the uptake and utilisation

of a screening and brief intervention package by GPs were evaluated in a controlled trial (Strand 3) [6].

ORIGINS AND BROAD FEATURES OF THE PHASE IV STUDY

Following on from previous phases in the Collaborative Project, Phase IV investigators agreed to develop and evaluate country-wide strategies for the widespread, routine and enduring implementation of early identification and brief intervention (EIBI) in the PHC systems of participating countries. Whereas earlier phases had applied a single study design adapted to the situation of each participating country, Phase IV represented a collection of studies that shared the same overall objective but with the design and procedures adapted to take account of the very different contexts of PHC in the participating countries. However, this flexibility was contained within clearly defined parameters with all studies sharing four common components [7]:

a) create customized materials and services;
b) reframe understandings of alcohol issues;
c) establish lead organizations and build strategic alliances;
d) establish and evaluate demonstrations.

Phase IV was thus a much more practical and policy-oriented group of studies than seen in previous phases of the WHO Collaborative Project. It was in many ways an example of action research [8] in which the central aim was to make a significant difference to the "real world" conditions under which brief interventions are disseminated in a particular country and to establish a programme of action leading to the widespread, country-wide implementation of EIBI in PHC. Action research is

especially suited to the goal of filling the gap between research evidence and practice, as in the field of EIBI where impressive research evidence of effectiveness in PHC [e.g., 9] is accompanied by equally firm evidence of a failure to implement EIBI in practice [e.g., 10]. A further difference from previous phases was that, in terms of research methods, qualitative approaches often assumed equal or greater importance than quantitative methods in Phase IV.

LIMITATIONS AND ACHIEVEMENTS OF PHASE IV

Despite its flexible nature across participating countries, a few broad generalisations regarding the collective experience of the Phase IV study can be made. First, the well-known description in 1987 of the attempt to involve PHC staff in the detection and management of alcohol problems [11] as "a difficult business" was amply confirmed 20 years later. This occurred despite the fact that in many cases the principal investigators were themselves GPs. This increased the credibility and practical relevance of the study but was clearly insufficient to engender the full co-operation of those it sought to enlist in action research. Possible reasons for this relatively disappointing response and possible solutions are discussed in the WHO Report [1].

A related problem was lack of support from governmental authorities. With some notable exceptions among participating countries, this was found at all levels of government – local, regional and national. A specific facet of this lack of support was the difficulty found in persuading authorities to include alcohol EIBI in health promotion campaigns and strategies and in plans for the regulation and reimbursement of PHC activity. This probably reflects the long-standing failure by governments to recognise the full extent of alcohol-related harm.

An important argument in attempting to persuade governments to support EIBI is that it leads to tangible economic benefits for society – the claim that the costs of delivering EIBI in PHC are more than offset by reductions in costs of the future use of health services. While there is evidence that such cost-offsets do occur, this comes mostly from the USA [e.g., 14] and there is a need for similar demonstrations in other health care systems. While it was recognised that a full and rigorous economic evaluation would be beyond the resources of most participating countries in Phase IV, it was hoped that a start could be made by at least calculating the costs of delivering EIBI. Unfortunately, these intentions were not fulfilled; with a few exceptions, participating countries were not able to mount an economic study of the kind envisaged. This should be included in countries' further plans to gather government support for EIBI in PHC after the end of the Phase IV study.

It was in the customisation component of the study that most progress was made. Using focus groups and Delphi surveys, all participating countries succeeded in making adaptations to materials or procedures involved in EIBI implementation – screening instruments and methods of delivery, the intervention package and its delivery, the EIBI training programme – to suit the requirements of the local health system and socio-cultural setting.

With regard to the reframing component of the study, the concept of hazardous drinking and its relevance to public health was introduced without much difficulty to a range of PHC professionals and other stakeholders in formal training programmes and in other ways. But while the attempt to reframe understandings of alcohol issues

among health professionals met with much success, this did not extend to the general public. To shift the general public towards a broadened understanding of alcohol problems, and away from an exclusive focus on "alcoholism", would presumably require the support and financial backing of central governments.

One palpable achievement of the Phase IV study was the establishment in each participating country of a lead organisation for the country-wide implementation of EIBI that could serve as a base for future developments in this field of work. At the same time, all these lead organisations succeeded in gathering endorsements from a range of organisations and individuals highly relevant to the aims of the study. Thus, the foundations of a broad movement of support for the widespread, routine and enduring implementation of EIBI in PHC were laid down, as was the original intention of the study protocol.

All Phase IV demonstration projects made some contribution to showing how widespread implementation could be achieved in the circumstances of the country in question but the majority were simple before-after designs. There remains a need for the more ambitious kind of study originally envisaged by Phase IV investigators but rejected as too expensive for most participating countries. First, we need firm evidence that particular methods of achieving routine implementation are more effective than others since this cannot be taken for granted. For instance, there is good evidence that clinical guidelines alone are insufficient for this purpose [13]. Although they are complex in design and expensive to run, the firm evidence required can only come from adequately controlled quasi-experimental studies or cluster RCTs [14]. Moreover, we do not have evidence yet that the beneficial public health effects of

routine and widespread implementation of EIBI in PHC can be detected at a community level in reduced levels of hazardous alcohol consumption and indices of alcohol-related harm in the population at large (e.g., morbidity and mortality statistics, drunkenness arrests, drink-driving offences, etc.). Again, such evidence could only be obtained from adequately controlled community-based studies.

FUTURE DEVELOPMENTS

Without exception, the work initiated in the Phase IV study will continue in all the countries taking part and there are encouraging signs that governments around the world are beginning to realise the potential benefits of widespread EIBI in PHC as one effective means of responding to a rising tide of alcohol problems in their societies. This was partly seen in the Phase IV study in which, towards the end of the research, some governments of participating countries began to include alcohol EIBI in national strategies to combat alcohol-related problems.

At the same time, the aims of Phase IV have been taken up on a wider international stage. As well as the majority of countries taking part in Phase IV, the EU-funded *Primary Health Care European Project on Alcohol* (PHEPA) (15) included 12 additional European countries in its first stage (2002-05) and a total of 24 countries in its second stage (2006-08). While sharing the goal of achieving routine implementation of EIBI in PHC, PHEPA entails the development and roll-out of four related products: (i) clinical guidelines for delivering EIBI in PHC that can serve as a basis for guidelines to be used in participating countries; (ii) a training manual linked to the clinical guidelines that can also be adapted for use in participating countries; (iii) a website containing an *Alcohol Management Database* for use by PHC

professionals and others interested in the promotion of EIBI in primary care; and (iv) a country-based strategy aimed at integrating EIBI for hazardous and harmful drinkers in the PHC systems of participating countries. Another WHO Collaborative Project is seeking to disseminate brief interventions in the PHC systems of developing countries and a start has been made in South Africa and Brazil (16). Finally, following on from Phase IV an international network was formed (International Network on Brief Interventions for Alcohol Problems: INEBRIA) to share ideas and increase communication among researchers and practitioners interested in alcohol EIBI [17]. Thus, in addition to its achievements in the participating countries, Phase IV has contributed to an international movement dedicated to reducing alcohol-related harm by achieving the widespread, routine and enduring implementation of EIBI for hazardous and harmful alcohol consumption, a movement that is steadily gathering momentum.

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